3600

Providence

AUTHORIZATION TO USE, DISCLOSE & RELEASE PROTECTED HEALTH INFORMATION

I understand the following:

- I have the right to refuse to sign this form for authorization to disclose or release my protected health information. Refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign this authorization may affect my ability to receive health care services is if the health care services are research-related or solely for the purpose of providing health information to someone else and the authorization is needed to make that disclosure.
- There may be a fee associated with this request.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.
- I have the right to receive a copy of this signed authorization.
- I may revoke this authorization in writing at any time. If I revoke this authorization, the information described below may no longer be used or disclosed for the purposes described in the written authorization. The only exception is when PH&S have taken action in reliance on the authorization or the authorization was obtained as a condition of insurance coverage.

To revoke this authorization, send a written statement that you are revoking this authorization along with a copy of this authorization to:

Providence Cedar-Sinai Tarzana Medical Center
Attn: Release of Information
18321 Clark Street, Tarzana, CA 91356
Phone: (818) 708-5367 | Fax: (818) 708-5368

Important: Providence Health & Services no longer print or release patient social security numbers unless required for billing. However, social security numbers may be included in patient information that is more than a few years old. The information you are authorizing to be released may include your social security number.

The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Providence Health & Services and its Affiliates do not discriminate on the basis of race, color, national origin, sex, age, or disability in their health programs and activities.

ATTENTION: If you do not speak English, you have at your disposal free language assistance services. Call (888) 311-9127 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (888) 311-9127 (TTY: 711).

注意：如果您講中文，我們可以給您提供免費中文翻譯服務，請致電 (888) 311-9127 (TTY: 711).

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I authorize Providence Health & Services to use and disclose a copy of the specific health information described below regarding:

Patient Name: _____ DOB: _____

Patient/Representative Name: _____ Phone: _____

To be disclosed to: ☐ Self Or Recipient's Name: _____

Recipient's Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Please send my records via: ☐ MyChart ☐ Email ☐ Disc ☐ Paper ☐ Fax

I am requesting information from the following facility(s):

List Hospital(s) or Provider Name(s)	List Clinic(s) or Provider Name(s)

For the range of dates from: _____ to: _____

For information related to the following diagnosis or injury: _____

Information to be disclosed:	
☐ History & Physical	☐ Discharge Summary
☐ Operative Report	☐ Emergency Department Report
☐ Diagnostic Reports (lab, x-ray, EKG, etc.)	☐ Progress Notes
☐ Other (specify):	

For the purpose of: _____

Unless revoked, this authorization expires in 180 days or on this date: _____

I understand and agree that the information below will be disclosed if I place my initials in the applicable space next to the type of information.

_____ HIV/AIDS testing/treatment _____ Mental Health specific visits

_____ Genetic Testing _____ Drug/Alcohol specific visits

Patient Signature: _____ Date: _____

(Print form and sign by hand)

Representative Signature: _____ Relation to Patient: _____

(Print form and sign by hand. Please include supporting documentation.)